STATE OF NORTH CAROLINA
TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN

ENROLLMENT APPLICATION

Is rehire within 12 months of previous State employment termination? ☐ Yes ☐ No

☐ Decline Coverage

RETURN APPLICATION TO THE HEALTH BENEFITS REPRESENTATIVE • PLEASE TYPE OR PRINT CLEARLY • DO NOT WRITE IN SHADED AREAS

1	SOCIAL SECURITY NUMBER	EMPLOYEE LAST NAME	FIRST NAME		INITIAL
2	**MARITAL STATUS:** ☐ SINGLE	☐ SEPARATED	☐ DIVORCED	☐ MARRIED	☐ WIDOWED
3	BIRTHDATE ___/___/___	SEX ☐ MALE ☐ FEMALE	TELEPHONE *(HOME)*	TELEPHONE *(WORK)*	
4	MAILING ADDRESS: BOX/STREET/RT. NUMBER	CITY	COUNTY	STATE	ZIP CODE
5	DOES WAITING PERIOD APPLY? ☐ YES	☐ NO			
6	TYPE OF COVERAGE REQUESTED ☐ EMPLOYEE ONLY	☐ EMPLOYEE/CHILD(REN)	☐ EMPLOYEE/FAMILY		
7	**COMPLETE IF YOUR SPOUSE IS AN ACTIVE OR RETIRED NC TEACHER OR STATE EMPLOYEE** →	NAME OF SPOUSE	SOCIAL SECURITY NUMBER		

DEPENDENT INFORMATION → **List dependents to be included.** Specify last name if different. Complete Certification of Dependent Eligibility Form for any starred (*) items checked.

	NAME *(First, Middle Initial, Last)*	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD IS MY:	COMPLETE BELOW IF CHILD IS OVER 19:	MEDICARE ELIGIBLE?	EMPLOYING UNIT MUST COMPLETE DOES WAITING PERIOD APPLY?
8	SPOUSE		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE			☐ YES *(See lines 13 &14)* ☐ NO	☐ YES ☐ NO
9	CHILD 1		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ Natural ☐ Foster* ☐ Adopted ☐ Step	☐ Student *(see line 12)* ☐ Handicapped	☐ YES *(See lines 13 &14)* ☐ NO	☐ YES ☐ NO
10	CHILD 2		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ Natural ☐ Foster* ☐ Adopted ☐ Step	☐ Student *(see line 12)* ☐ Handicapped	☐ YES *(See lines 13 &14)* ☐ NO	☐ YES ☐ NO
11	CHILD 3		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ Natural ☐ Foster* ☐ Adopted ☐ Step	☐ Student *(see line 12)* ☐ Handicapped	☐ YES *(See lines 13 &14)* ☐ NO	☐ YES ☐ NO

12 **IF FULL-TIME STUDENT, LIST DEPENDENT'S FIRST NAME AND UNIVERSITY, COLLEGE OR ACCREDITED VOCATIONAL SCHOOL**

MEDICARE INFORMATION → List below yourself and any other persons to be covered who are eligible for Part A and/or B of Medicare.

	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO	EFFECTIVE DATE ENROLLED FOR PART A (MM/DD/YY)	EFFECTIVE DATE ENROLLED FOR PART B (MM/DD/YY)
13			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	___/___/___	___/___/___
14			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	___/___/___	___/___/___

15 **OTHER GROUP HEALTH COVERAGE** → ☐ YES Complete if you or your dependents have other group health coverage currently in effect.
☐ NO If you or your dependents had other coverage that ended within the past 63 days, complete the Prior Coverage Information form.

16	NAME & ADDRESS OF OTHER PLAN OR INSURANCE COMPANY		POLICY/PLAN NUMBER
17	NAME & ADDRESS OF EMPLOYER UNDER WHICH THIS COVERAGE IS PROVIDED	TYPE OF COVERAGE ☐ SELF ONLY ☐ FAMILY ☐ OTHER	NAME OF POLICYHOLDER
18	COMMENTS		

EMPLOYEE AUTHORIZATION

I hereby elect coverage under the plan listed above for myself and eligible family dependents listed on the form above, and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the plan.

I hereby authorize my employer to deduct from my earning any deduction for the coverage elected above.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medically-related facility, insurance company, or other organization or institution that has any records or knowledge of the health of any covered member of my family to exchange such information with the plan.

EMPLOYEE'S SIGNATURE _____ DATE SIGNED ___/___/___ Desired effective date of coverage ___/01/___

EMPLOYING UNIT MUST COMPLETE	EMPLOYING UNIT NAME	DOES MEDICARE REDUCED RATE APPLY? ☐ YES ☐ NO	GROUP NUMBER	PAYROLL NUMBER	SECTION NUMBER
	EMPLOYEE DEDUCTION $	EMPLOYER CONTRIBUTION $	DATE OF EMPLOYMENT	EFFECTIVE DATE	PART-TIME TO FULL-TIME EMPLOYMENT DATE

PINK COPY SHOULD BE RETAINED BY THE EMPLOYEE AND USED AS A TEMPORARY ID CARD
YELLOW - EMPLOYING UNIT WHITE - SUBMIT TO INSURANCE PLAN

COMPLETING THE ENROLLMENT APPLICATION [C9]
(FORMS DATED ON OR AFTER 7/02)

Top of Form Check whether the enrollee is a rehire within 12 months of previous State employment.

If an employee chooses to decline coverage, check the "Decline Coverage" box, have employee sign and date, then retain application form.

Line 1 Fill in your social security number and name.

Line 2 Check appropriate box for marital status.

Line 3 Fill in your date of birth and check the appropriate box for sex. Print your home and work phone numbers.

Line 4 Fill in your address.

Line 5 Completed by Health Benefits Representative.

Line 6 Check the type of coverage desired. If you want Employee-Child/ren coverage, list the name(s) of the child(ren) to be covered on Lines 9 through 11. If you want to include your spouse as well as child(ren), check the box for "Family" and give the information about your spouse on Line 8 and your child(ren) on Lines 9 through 11.

Line 7 If your spouse is an active or retired State employee or teacher, give your spouse's name and enter your spouse's social security number.

Line 8 If you want coverage for your spouse, give his/her first name, middle initial, last name if it is different from yours, and your spouse's social security number. Enter your spouse's date of birth and sex.

Check "yes" or "no" to indicate whether your spouse is eligible for Medicare. If "yes" is checked, complete Lines 13 or 14.

Lines 9 through 11 If you want coverage for your eligible dependent child(ren), print each child's name, middle initial, and the child's social security number. For each child whose last name is different from yours, give the child's last name and complete a Certification of Dependent Eligibility Form [available from your Health Benefits Representative (HBR)]. Attach it to this application.

Enter each child's date of birth and sex. Check the box that most accurately describes this dependent's association/relationship to you. If you have a child over 19 who is a full-time student and eligible to be

COMPLETING THE ENROLLMENT APPLICATION DATED ON OR AFTER 7/02 (CONTINUED)

covered, check "student." If you have a child over age 19 who is eligible as a mentally or physically incapacitated

dependent, check "handicapped" and fill out a Coverage Request for Mentally or Physically Incapacitated Children (available from your HBR). Attach it to this application.

Check "yes" or "no" to indicate whether your child is eligible for Medicare. If "yes" is checked, complete Lines 13 or 14.

Line 12 If you checked "student" for any dependent child(ren) listed on Lines 9 through 11, give the dependent's name and the name of the accredited school or college that the dependent is attending.

Lines 13 and 14 If you, your spouse, or any of your children listed on Lines 9 through 11 are eligible for Medicare, give the name, Medicare claim number, reason for Medicare eligibility, and the dates enrolled in Part A and Part B for each person who is eligible for Medicare.

Line 15 Check "yes" or "no" to indicate whether any participant listed to be covered has other employer-sponsored group health coverage.

Lines 16 and 17 If "yes" was checked on line 15, please provide the following information:

- Name and complete address of the other carrier
- Policy number
- Name and address of the employer under which the coverage is provided
- Type of coverage provided
- Name of policyholder

Authorization

Read this statement carefully, ***sign*** and ***date*** the form. Fill in the desired effective date of coverage. Your HBR will complete the remaining information. Once your have ***signed*** the form, ***separate*** and ***keep*** the pink copy of the application for your records.